



DDHC PFCP

Member Application

Thank you for taking the time to complete this application for the DDHC Patient Family Partnership Council. Please provide brief, descriptive answers to the following questions.

1. What are some of the specific things that health care professionals at DDHC do/have done to help you or your family? The health care professional can be a nurse, a physician's assistant, a doctor or someone at the front desk.

2. What are some of the things you would DDHC to do differently to better help patients and their families?

3. Are there certain topics or areas of the clinic in which you have a special interest?

4. Why are you interested in joining the Patient and Family Advisory Council?

5. Please outline one activity that you participated in as a team member—such as a sport, community event or work-related activity—and how you view your contribution to achieve effective teamwork.

6. What positive improvements to patient care would you like to see as a result of your participation in the Patient and Family Advisory Council?



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7. Is there anything else that you would like to add?

If you are selected to be a participant, can you commit to attend one meeting each quarter from on a Thursday from 1200-1300? (Circle one)

YES NO

Are you willing to interview and be interviewed by another council participant? (Circle one)

YES NO

Are you willing to sign a confidentiality agreement? (Circle one)

YES NO

Please provide your contact information:

Address:

Phone:

Preferred email address:

What is your preferred contact method? (Circle one) email phone mail

What is your preferred contact time? (Check all that apply)

☐ M-F morning

☐ Weekend morning

☐ M-F afternoon

☐ Weekend afternoon

☐ M-F evening

☐ Weekend evening

How would you describe yourself? (Check all that apply) (Optional)

☐ White

☐ Hispanic/Latino

☐ Black /African American

☐ Other

What is your age? ____